peripheral blood stem cells, or cord blood (but not including embryonic stem cells).

(3) A subsection (d) hospital that furnishes inpatient allogeneic hematopoietic stem cell transplants is required to hold all allogeneic hematopoietic stem cell acquisition charges and bill them to Medicare using the appropriate revenue code, when the transplant occurs.

(4) A subsection (d) hospital must maintain an itemized statement that identifies, for all costs defined in paragraph (e)(2) of this section, the services furnished in collecting hematopoietic stem cells including all invoices or statements for purchased services for all donors and their service charges. Records must be for the person receiving the services (donor or recipient; for all donor sources, the hospital must identify the prospective recipient), and the recipient's Medicare beneficiary identification number.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §412.113, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

§412.115 Additional payments.

(a) *Bad debts.* An additional payment is made to each hospital in accordance with §413.89 of this chapter for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.

(b) *Administration of blood clotting factor.* For discharges occurring on or after June 19, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997, an additional payment is made to a hospital for each unit of blood clotting factor furnished to a Medicare inpatient who is a hemophiliac. For discharges occurring on or after October 1, 2005, the additional payment is made based on the average sales price methodology specified in subpart K, part 414 of this chapter and the furnishing fee specified in §410.63 of this subchapter.

(c) *QIO reimbursement for cost of sending requested patient records to the QIO.* An additional payment is made to a hospital in accordance with §476.78 of this chapter for the costs of sending requested patient records to the QIO in electronic format, by facsimile, or by photocopying and mailing.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 55 FR 15175, Apr. 20, 1990; 56 FR 43448, Aug. 30, 1991; 57 FR 39825, Sept. 1, 1992; 57 FR 47787, Oct. 20, 1992; 58 FR 46339, Sept. 1, 1993; 62 FR 46030, Aug. 29, 1997; 68 FR 67960, Dec. 5, 2003; 70 FR 47486, Aug. 12, 2005; 85 FR 59022, Sept. 18, 2020]

§412.116 Method of payment.

(a) *General rules.* (1) Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge based on the submission of a discharge bill.

(2) Payments for inpatient hospital services furnished by an excluded psychiatric unit of a hospital (or by an excluded rehabilitation unit of a hospital for cost reporting periods beginning before January 1, 2002) are made as described in §§413.64(a), (c), (d), and (e) of this chapter.

(3) For cost reporting periods beginning on or after January 1, 2005, payments for inpatient hospital services furnished by an inpatient psychiatric facility that meets the conditions of §412.404 are made as described in §412.432.

(4) For cost reporting periods beginning on or after January 1, 2002, payments for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit that meets the conditions of §412.604 are made as described in §412.632.

(5) For cost reporting periods beginning on or after October 1, 2002, payments for inpatient hospital services furnished by a long-term care hospital that meets the conditions for payment of §§412.505 through 412.511 are made as described in §412.521.

(b) *Periodic interim payments*—(1) *Criteria for receiving periodic interim payments.* Effective with claims received on or after July 1, 1987, a hospital that meets the criteria in §413.64(h) of this chapter may request in writing to receive periodic interim payments as described in this paragraph. A hospital that is receiving periodic interim payments also receives payment on this basis for inpatient hospital services

furnished by its excluded psychiatric or rehabilitation unit.

(i) *Failure of intermediary to make prompt payment.* Beginning with claims received in April 1987, the hospital's fiscal intermediary does not meet the requirements of section 1816(c)(2) of the Act, which provides for prompt payment of claims under Medicare Part A, for three consecutive calendar months. The hospital may continue to receive periodic interim payments until the intermediary meets the requirements of section 1816 (c)(2) of the Act for three consecutive calendar months. For purposes of this paragraph, a hospital that is receiving periodic interim payments as of June 30, 1987 and meets the requirements of §413.64(h) of this chapter may continue to receive payment on this basis until the hospital's intermediary meets the requirements of section 1816(c)(2) of the Act for three consecutive calendar months beginning with April 1987.

(ii) *Hospitals that serve a disproportionate share of low-income patients.* The hospital is receiving periodic interim payments as of June 30, 1987 and has a disproportionate share payment adjustment factor of at least 5.1 percent as determined under §412.106(c) for purposes of establishing the average standardized amounts for discharges occurring on or after October 1, 1986 and before October 1, 1987. The hospital's request must be made by a date prior to July 1, 1987, specified by the intermediary.

(iii) *Small rural hospitals.* The hospital is receiving periodic interim payments as of June 30, 1987, makes its request by a date prior to July 1, 1987, specified by the intermediary, and, on July 1, 1987, the hospital—

(A) Is located in a rural area as defined in §412.62(f); and

(B) Has 100 or fewer beds available for use.

(2) *Frequency of payment.* The intermediary estimates a hospital's prospective payments as described in paragraph (b)(3) of this section and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. Each payment is made two weeks after the end of a biweekly period of service, as described in §413.64(h)(5) of this chapter. These payments are subject to final settlement.

(3) *Amount of payment.* (i) The biweekly interim payment amount is based on the total estimated Medicare discharges for the reporting period multiplied by the hospital's estimated average prospective payment amount as described in paragraph (b)(3)(ii) of this paragraph. These interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a hospital receives interim payments for less than a full reporting period.

(ii) For purposes of determining periodic interim payments under this paragraph, a hospital's estimated average prospective payment amount is computed as follows:

(A) If a hospital has no payment experience under the prospective payment system for operating costs, the intermediary computes the hospital's estimated average prospective payment amount for operating costs by multiplying its payment rates as determined under §412.70(c), but without adjustment by a DRG weighting factor, by the hospital's case-mix index, and subtracting from this amount estimated deductibles and coinsurance.

(B) Effective for cost-reporting periods beginning on or after October 1, 1991, the intermediary computes a hospital's estimated average prospective payment amount for capital-related costs by multiplying its prospective payment rate as determined under §412.340 or §412.344(a), as applicable, and under §412.308 for cost reporting periods beginning on or after October 1, 2001 but without adjustment by a DRG weighting factor, by the hospital's case-mix index. The intermediary may take into account estimated additional payments per discharge under §412.348. If the hospital is paid under §412.344(a)(1), the intermediary includes an estimated payment for old capital costs per discharge.

(C) If a hospital has payment experience under the prospective payment system for operating costs, and, for cost reporting periods beginning on or after October 1, 1991, for inpatient capital-related costs, the intermediary

computes a hospital's estimated average prospective payment amount for operating costs and capital-related costs based on that payment experience, adjusted for projected changes, and subtracts from this amount estimated deductibles and coinsurance.

(4) *Termination of periodic interim payments*—(i) *Request by the hospital.* A hospital receiving periodic interim payments may convert to payments on a per discharge basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates periodic interim payments if—

(A) A hospital no longer meets the requirements of §413.64(h);

(B) A hospital is receiving payment under the criterion in paragraph (b)(1)(i) of this section and the intemediary meets the prompt payment requirements of section 1816(c)(2) of the Act for three consecutive calendar months; or

(C) A hospital that is receiving payment under the criterion set forth in paragraph (b)(1)(iii) of this section no longer meets the criterion.

(iii) *Limitation on reelection.* If a hospital that is receiving periodic interim payments under the criterion set forth in paragraph (b)(1)(ii) or (b)(1)(iii) of this section is removed from that method of payment at its own request, it may reelect to receive periodic interim payments only under the criterion set forth in paragraph (b)(1)(i) of this section. However, if the hospital is removed from that method of payment by its intermediary because it no longer meets the requirements of §413.64(h) of this chapter, that hospital may subsequently reelect to receive periodic interim payments if it qualifies under the provisions of paragraph (b)(1)(ii) or (b)(1)(iii) of this section, subject to the requirements in §413.64(h) of this chapter.

(c) *Special interim payments for certain costs.* For capital-related costs for cost-reporting periods beginning before October 1, 1991 and the direct costs of medical education, which are not included in prospective payments but are reimbursed as specified in §§413.130 and 413.85 of this chapter, respectively, interim payments are made subject to final cost settlement. Interim payments for capital-related items for cost-reporting periods beginning before October 1, 1991 and the estimated cost of approved medical education programs (applicable to inpatient costs payable under Medicare Part A and for kidney acquisition costs in hospitals approved as renal transplantation centers) are determined by estimating the reimbursable amount for the year based on the previous year's experience and on substantiated information for the current year and divided into 26 equal biweekly payments. Each payment is made two weeks after the end of a biweekly period of services, as described in §413.64(h)(5) of this chapter. The interim payments are reviewed by the intermediary at least twice during the reporting period and adjusted if necessary.

(d) *Special interim payment for unusually long lengths of stay*—(1) *First interim payment.* A hospital that is not receiving periodic interim payments under paragraph (b) of this section may request an interim payment after a Medicare beneficiary has been in the hospital at least 60 days. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.

(2) *Additional interim payments.* A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under paragraph (d)(1) of this section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of this paragraph (d).

(e) *Outlier payment and additional payments for new medical services and technologies.* Payments for outlier cases and additional payments for new medical services and technologies (described in subpart F of this part) are not made on an interim basis.

(f) *Accelerated payments*—(1) *General rule.* Upon request, an accelerated payment may be made to a hospital that is

not receiving periodic interim payments under paragraph (b) of this section if the hospital is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the hospital.

(ii) Due to an exceptional situation, there is a temporary delay in the hospital's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* A hospital's request for an accelerated payment must be approved by the intermediary and CMS.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as hospital bills are processed or by direct payment by the hospital.

[53 FR 1627, Jan. 21, 1988, as amended at 53 FR 38532, Sept. 30, 1988; 54 FR 36495, Sept. 1, 1989; 56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992; 59 FR 36712, July 19, 1994; 59 FR 45400, Sept. 1, 1994; 66 FR 41387, Aug. 7, 2001; 67 FR 56049, Aug. 30, 2002; 68 FR 45470, Aug. 1, 2003; 69 FR 66977, Nov. 15, 2004; 71 FR 48140, Aug. 18, 2006]

§ 412.120 Reductions to total payments.

(a) *Deductible and coinsurance.* Subject to paragraph (a)(2) of this section, the total Medicare payments otherwise payable to a hospital are reduced by the applicable deductible and coinsurance amounts related to inpatient hospital services as determined in accordance with §§ 409.82, 409.83, and 409.87 of this chapter.

(b) *Payment by workers' compensation, automobile medical, no-fault or liability insurance or an employer group health plan primary to Medicare.* If workers' compensation, automobile medical, no-fault, or liability insurance or an employer group health plan which is primary to Medicare pays in full or in part, the Medicare payment is determined in accordance with the following guidelines:

(1) If workers' compensation pays, in accordance with the applicable provisions of §§ 405.316 through 405.321 of this chapter.

(2) If automobile medical, no-fault, or liability insurance pays, in accordance with the applicable provisions of §§ 405.322 through 405.325 of this chapter.

(3) If an employer group health plan which is primary to Medicare pays for services to ESRD beneficiaries, in accordance with the applicable provisions of §§ 405.326 through 405.329 of this chapter.

(4) If an employer group health plan which is primary to Medicare pays for services to employees age 65–69 and their spouses age 65–69, in accordance with the applicable provisions of §§ 405.340 through 405.344 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 55 FR 36071, Sept. 4, 1990; 56 FR 573, Jan. 7, 1991; 57 FR 39825, Sept. 1, 1992]

§ 412.125 Effect of change of ownership on payments under the prospective payment systems.

When a hospital's ownership changes, as described in § 489.18 of this chapter, the following rules apply:

(a) Payment for the operating and capital-related costs of inpatient hospital services for each patient, including outlier payments, as provided in § 412.112, and payments for hemophilia clotting factor costs under § 412.115(b), are made to the entity that is the legal owner on the date of discharge. Payments are not prorated between the buyer and seller.

(1) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a beneficiary regardless of when the beneficiary's coverage began or ended during a stay, or of how long the stay lasted.

(2) Each bill submitted must include all information necessary for the intermediary to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.

(b) Other payments under § 412.113 and payments for bad debts as described in § 412.115(a), are made to each owner or operator of the hospital (buyer and seller) in accordance with